Venue:
Tribal Clinic

Goal:
Promote Quitting of Tobacco Use

Activity:
C3.04 Health Care Systems Change/Trainings

Contact Information:
Nancy Meyer
Organization:
Puyallup Tribal Health Authority
Phone:
(253) 593-0232 ext 513
Email:
nancymc@ptha.ihs.gov

Washington State Department of Health
Tobacco Prevention & Control Program

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER WASHINGTON

A Tribal Clinic System to Treat Nicotine Dependence

Project Description

The Puyallup Tribal Health Authority (PTHA) implemented the Public Health System Guidelines for treating tobacco use dependence in their tribal health clinic system.

Policies People Changing the environment Practices
Tobacco Prevention & Control 2004 Annual Conference

Inputs

Rationale

- American Indians/Alaska Natives have the highest rate of smoking of all race and ethnic groups in the United States. Washington State Department of Health 2002 data cites smoking rates for Pierce County Native Americans/Alaskan Natives (18 and over) was 40 percent *(BRFSS)* and reduced excess health care costs.
- Respiratory problems are the number one cause of ambulatory visits among the 10,000 patients seen yearly at the clinic. The social and economic cost to the community as a result of smoking related diseases are tremendous. The community loses valuable traditions and history, and families suffer the loss of a loved one.
- Using a research-based approach, an internal advisory board of clinic managers, staff, and administrators chose to implement the Public Health Service best practice clinic guidelines for treating tobacco use. Research consistently shows that implementing all six steps of the guidelines reduces tobacco use (Public Health Service, June 2000).
- Reducing tobacco use is a goal of the tribal authority's strategic plan and is an integral part quality of patient care. Reducing the smoking rate among American Indians/Alaska Natives will reduce morbidity and mortality rates as well as the number of children exposed to secondhand smoke.
- Quit attempts are twice as likely to occur among smokers who report getting advice to quit from their physicians (Fiore, 1990). Group Health Cooperative of Puget Sound reduced tobacco use among its user population by 40 percent within ten years of implementing the guidelines and reduced excess health care costs.

Target Audiences
- Primary: Adult smokers (to increase quit attempts) and all clinic patients age 6 and up (to reduce exposure to secondhand smoke and prevent use).
- Secondary: Former smokers to prevent relapse.

Resources

Staff
- An internal advisory board, which is made of key decision makers from all six clinics and the tobacco program coordinator, were involved in all aspects of program design and implementation.
- The advisory board met one-hour, bi-weekly for two years and now meets monthly to monitor program outcomes and to ensure compliance of objectives.
- The tobacco program coordinator spends about 30 hours a week on the continued development and implementation of the system, cessation counseling, staff training, chart reviews, and data collection.

Funding
- Funding came from the state Tobacco Prevention and Control Program, a Smoke Free Families Grant from the federal Centers for Disease Control and Prevention, and the PTHA.

Partnerships
- Group Health's Center for Health Promotion provided technical assistance.

Activities

1. Interviews were completed with key clinicians, administration, and staff involved in tobacco prevention activities to assess their practice of interventions. The results were presented to the 26-member management team to ensure buy-in for development of a comprehensive clinic system.
2. From this process the internal tobacco advisory board was formed. The advisory board reviewed the needs assessment, data from the clinic data system, and Group Health's policy and procedures, and then developed an action plan.
3. The advisory board wrote program goals, objectives and protocols and distributed them to the clinic departments for review and comment.
4. Training on the clinic system and the brief intervention model was developed and delivered to the medical and dental clinic staff.
5. The clinic system was pilot tested in both medical and dental clinics for more than a year. Revisions were made based on chart reviews and clinician interviews. A brochure on the new clinic system was developed and distributed to patients.
6. The system was implemented in the remaining departments: mental health, pharmacy, and community health in 2003.
7. The system is monitored through quarterly chart reviews and revisions are made as needed to ensure outcomes.

Outputs

A variety of clinic managers and staff were involved in developing and implementing the clinic system:

1. Thirteen one-on-one interviews were completed with key decision makers.
2. Twenty-six department managers attended the initial presentation on the needs assessment and clinic data.
3. Fifteen key decision makers reviewed program models.
4. More than 50 clinic staff provided input on forms and protocols.
5. The four-hour basic tobacco skills intervention certification training has been attended by 77 clinic staff members.
6. More than 1,000 charts were reviewed during the pilot implementation.
7. More than 50 dental and medical staff attended a meeting about the results of the pilot.
8. The one-on-one cessation program sees 20 patients every week.
9. The system was implemented in all six of the tribal authority clinics.
10. The system is monitored regularly and revisions are made as needed to assure outcomes.
11. Chart reviews are conducted quarterly and reports are made to individuals and departments to ensure effective implementation.
12. More than 1,000 brochures on the clinic cessation program have been distributed to smokers.

Evaluation

- Cessation program results are reviewed yearly. To date 90 percent of those completing the intensive cessation program have successfully quit for six months or more and 85 percent are smoke-free at one year. The overall quit rate is 36 percent.
- Provider compliance data is gathered through chart reviews and the Indian Health Service Data Collection System. Tobacco use rates are obtained from that same data system.

Lessons Learned

- It takes at least a .5 FTE to lead the process of development and implementation.
- Interdepartmental collaboration is a critical component for continuity of care.
- Commitment of decision makers is essential for system integration.
- Ongoing review and provider education is necessary for system maintenance. Revisions are a part of system maintenance.
- The entire clinical staff needs to have input from the beginning of the process.
- The Public Health System Guidelines can be fully implemented in a tribal clinic without alterations, but brief interventions need to be culturally sensitive.